VIRGINIA DEPARTMENT OF HEALTH

Patient Application and Consent for Health Care CHS-1A

Patient Name **Patient ID** **Date**

Thank you for using the services provided by _____, a local office of the Virginia Department of Health. **It is our pleasure to serve you and your family**.

PAYMENT FOR SERVICES / RECORD KEEPING

Although some of our services are free, we do charge for many of them. You will be responsible for paying for those services for which you are charged. We do have a sliding fee scale that, based on your family income and family size, may lower the charges you must pay. The percentage you pay will remain the same until your income or family size change. It is possible that our charges may change. We will try to discuss those changes with you.

Based on the information you have provided to us, you are responsible for paying 0 % of the charges.

If there is a charge for the services and you do not pay for the services we have provided to you, we will add penalty charges such as a 10% late fee, a 30% collection fee for a collection agency and/or debt-set off, which means the Department of Taxation will take what you owe us out of your state tax refund or any lottery winnings. In addition, if the account if forwarded to the Attorney General's office, there will be an additional 30% legal fee. It is in your best interest to pay on a regular basis.

I certify that the information I have provided is a true and complete statement according to my best knowledge and belief, and that a full explanation of services and charges has been given to me. I understand that if I give false information, withhold information, or fail to report changes promptly, I will be breaking the law and can be prosecuted and/or have services discontinued.

I give my permission for me and/or my dependent (named above) to be interviewed. I understand that I am responsible for paying my bill and that I will be penalized if I do not pay on time.

I authorize the Health Department to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third party payor to pay any authorized benefits to the Health Department on my behalf.

I understand that medical records will be retained for ten years after the date of the last visit or for five years following patient's death. In the case of a minor, the record will be retained ten years after the last visit or for five years after age 18, whichever comes later.

PATIENT CONSENT FOR GENERAL PRIMARY CARE

The deemed consent for HIV or Hepatitis B or C exposure has been explained to me, and I understand it.
_____ Yes _____ No

I hereby authorize the Physicians, Nurses, Nurse Practitioners, and/or other medical care providers of the Virginia Department of Health to examine and/or treat me and/or my dependent, as named above.

This consent remains in effect as long as I receive care in this health department or until I withdraw it.

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis Date Signed

_____ _____
Relationship (if signature is not of Patient) Signature of Person Obtaining Consent